IN-HOME SUPPORTIVE SERVICES
NEEDS ASSESSMENT-FACE SHEET

A. RECIPIENT INFORMATION

NAME:	CASE NO:	TELEPHONE: ( )	DOB (MO/DATE/YR)	SEX: *(CIRCLE ONE)* M F
ADDRESS (NUMBER, STREET):	IHSS COMPANION CASE(S), NAME(S) AND NUMBERS:			
CITY: / STATE: / ZIP CODE:				
RECIPIENT'S STATEMENT OF NEED:	SPECIAL DIRECTIONS:			
EMERGENCY CONTACTS/INSTRUCTIONS:	ALTERNATE RESOURCES USED: *(LIST SOURCE AND SERVICE PROVIDED)*			
SPECIAL CONDITIONS/MEDICAL PROBLEMS:				

B. MEDICAL INFORMATION

DIAGNOSIS/PROGNOSIS:	DATE OF MEDICAL REQUEST:

PHYSICIAN:	TELEPHONE: ( )	PHYSICIAN:	TELEPHONE: ( )
PHYSICIAN:	TELEPHONE: ( )	PHYSICIAN:	TELEPHONE: ( )

MEDICATIONS/PURPOSE

1.	4.	7.
2.	5.	8.
3.	6.	9.

C. OTHER PERSONS IN HOUSEHOLD

NAME	AGE	RELATIONSHIP	RECEIVE IHSS YES	RECEIVE IHSS NO	HOURS AT SCHOOL/ WORK	REASON PERSON CANNOT PROVIDE IHSS TO RECIPIENT

COMMENTS:

WORKER:	TELEPHONE: ( )	DISTRICT OFFICE:	DATE: